

Otis (F.N.)

*With Compliments of
F. N. Otis*

CHRONIC SPASMODIC STRICTURE ;

OR,

URETHRISMUS.

SECOND PAPER

In Reply to Dr. H. B. SANDS,

BY

F. N. OTIS, M. D.,



CLINICAL PROFESSOR OF GENITO-URINARY DISEASES IN THE COLLEGE OF PHYSICIANS AND
SURGEONS, NEW YORK ; SURGEON TO CHARITY HOSPITAL, FELLOW OF THE
NEW YORK ACADEMY OF MEDICINE, MEMBER OF THE
BRITISH MEDICAL ASSOCIATION, ETC.

REPRINTED FROM THE HOSPITAL GAZETTE, JUNE 28TH. 1879.

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It is, perhaps, not altogether unfortunate, when, in the course of a scientific discussion, a disputant, for the moment lacking scientific material suitable to repel an assault, seeks to evade it under the cover of personal allusions and side issues. These, and the anticipated rejoinder, usually stimulate the attention of an audience, and not unfrequently renew and increase its interest in the subject.

With this view of the case, I am glad to take advantage of the opportunity afforded me, by the reply of Dr. Sands to my previous paper, to correct some errors in matters of fact and some misapprehensions on his part, and in this way to confirm what I have previously asserted in regard to the reality and frequency of chronic spasmodic stricture, and of the dangers resulting from mistaking this purely functional contraction for true organic stricture.

It is not important to the appreciation of spasmodic stricture, that we should know who first discovered or originated the theory of reflex or sympathetic nerve disturbance, resulting in spasmodic urethral contractions; but it is important, in simple justice and honesty, that this scientific discovery should be credited to its proper source; that it should not be undervalued, by attaching to it names of individuals, whose only association with it consists in the accidental recognition of cases implying sympathetic nerve disturbance.

This side issue is made by Dr. Sands, when he contradicts my statement that "*the theory of reflex action as applied to urethral difficulties was first advanced by Civiale*," adding that "Civiale neither deserved nor claimed any credit for originality in this respect." He then devotes two full pages to quotations from ancient authorities to

show, that isolated and mysterious cases of irritation of the genito urinary apparatus, had been observed as associated with various more or less remote alleged sources of the trouble. Thus, according to "John Hunter writing," he says, "in 1776" * * * "I have known the urethra sympathize with the cutting of a tooth, producing all the symptoms of a gonorrhœa." etc., etc.

A couple of hours more of erudite labor, in any good medical library, might have doubled his list of similar curious urethral cases.

Dr. Sands has at least succeeded, by these irrelevant citations, in showing that effects much more extraordinary than chronic spasmodic stricture, have been known to result from even slighter causes than anterior urethral contractions. He fails to show, however, that any one of the authorities quoted, have ever advanced any theory or opinion in regard to the manner in which the reflex disturbance which they observed, was produced; nor that there had been any attempted generalization of such cases, and the facts connected with them, as might be of practical benefit to the profession. Consequently his laborious researches do not in the least affect my statement that Civiale was the first to deduce from these, and similar observations, a distinct and well sustained theory in regard to the cause of reflex urethral irritations and also in regard to their successful management.

Any doubt as to the correctness of this opinion will, I think, be set at rest by a perusal of the following from Civiale. Thus—

"Independent of its local sensitiveness, the urethra possesses another kind, which may be termed sympathetic. * * * When this sensitiveness is aggravated, it may awaken sympathetic response in every organ and function of the body. * * It is not rare to observe that slight encroachments-upon the urethral calibre induce marked difficulty in micturition: Those at the meatus having this effect not less than those located farther in. (*Traite Pratique des Maladies Genito-urinaires, Paris 1850, pp. 45 and 354*).

In regard to treatment by division of the contractions, he says:

"An effect so prompt, through means, the significance of which is

plain, shows that the slightest obstruction in the urethra is able to produce the gravest symptoms, local and general."

Following is a statement of the reflex theory, which Dr. Sands says in his first paper, (*Hospital Gazette*, Vol. 5, No. 7, page 127), "*was invented by the French Surgeon, Verneuil*," (1866). "Now, Verneuil, who appears never to have examined strictures by dissection, asserted as the result of clinical observation, that deep seated organic strictures so far from being common were extremely rare; and that in the immense majority of cases, supposed to be of this nature the real stricture would be found in the penile portion of the urethra, the contraction of the deeper segment being due to a reflex spasmodic action of the compressor urethræ muscle."

This was presented in 1866. Civiale's views were published in 1850. It will be remembered that Civiale says, "*independent of its local sensitiveness, the urethra possesses another kind which may be termed sympathetic.* * * * *When the sensitiveness is aggravated it may awaken sympathetic response in every organ and function of the body.*" Here is the statement of the "reflex theory as applied to urethral difficulties," for which I claimed priority for Civiale.

Again: "the constriction which seemed hardly to impede the flow of urine, is no sooner divided than all morbid symptoms vanish. * *

* An effect so prompt, through means of which the significance is plain, shows that the slightest obstruction in the urethra is able to produce the gravest symptoms, local and general."

Here then is the application of the theory.

Prof. Bigelow, of Boston, in speaking of Prof. Lister's connection with antiseptic surgery, in a recent lecture, touches aptly upon our duty to discoverers of scientific facts. On page 770, of the *Boston Medical Journal* of June 5th, he says: "He who first assembles imperfect and detached ideas, and by their means establishes a proposition beyond a doubt, and then brings his demonstration home to the conviction of the world—a measure which is all important to his claim—has fulfilled every condition, essential, not only to the private and secret discoverer, who has no claim to the world's gratitude

but also to the public discoverer, who lays the world under obligation, and is on that account recognized by it."

My own acknowledgment of what I believed to be due to M. Civiale, is used to my discredit; presented as a manifestation of undue humility.

Dr. Sands says, "he then offers an humble apology to Civiale, as the one who first advanced the theory of reflex action as applied to urethral difficulties." The "humble apology" reads as follows: "Now while I claim my own published views and observations prior to this date, to have been original with myself, I hasten to concede the honor of priority in this field to the distinguished French surgeon, to whom it fairly belongs." With the knowledge of exactly what Civiale taught, and the dates as presented in the preceding pages, it will be easy for the reader to judge as to the propriety and justice of according to Civiale the honor of being the first to advance "*the reflex theory as applied to urethral difficulties.*"

Dr. Sands complains that he is quoted by me as having said of M. Folet that "he had mistaken the triangular ligament for a muscular spasm." "This unmeaning sentence" he goes on, with some heat, to remark "was composed by Dr. Otis, and cannot be found in my paper."

Dr. Sands does not tell us what he really did say, but leaves the very natural inference that it was something essentially different, Not that something unimportant was omitted, but he says distinctly, that "the sentence was *composed* by Dr. Otis." Here is the sentence *verbatim et literatim*: "Two things are evident on reading Folet's paper: first, that the writer is unduly desirous of defending a favorite theory, and secondly, *that he has mistaken the natural obstacle situated in front of the triangular ligament for a muscular spasm.*"* Now, if Dr. Sands does not mean to state that M. Folet has mistaken a natural obstacle for a muscular spasm, what does he mean? And if, by "the natural obstacle," he does not mean the triangular ligament, what does he mean? Is there any practical difference between the

* Italics my own.

"natural obstacle in front of the triangular ligament"—*i. e.*, the tissues covering it—and the ligament itself? I leave the profession to judge. Dr. Sands characterizes my quotation as an "unmeaning sentence." I am willing to coincide fully in his estimate of it, and at the same time would suggest that this remark applies equally to what he did say. I accidentally, unintentionally, omitted the words "natural obstacle in front of," which to me, even now, appear unimportant—meaningless. If Dr. Sands thinks otherwise, will he explain, and also what he means when he says in his former paper;* p. 6, line 22. "If the point of the instrument, having arrived at the bulbo-membranous junction, is not directed with precision, it will, as you know, *impinge upon the triangular ligament* and be arrested in its course."† Why did Dr. Sands omit in this case "the natural obstacle in front of" if he considered it so important?

Dr. Sands calls attention to the four cases mentioned by Dr. Otis as having been operated on at the New York Hospital, and cites one of the cases in full. He then begs leave to "compare Dr. Otis' account with the following one condensed from Hospital case-book (vol. II., 1878, p. 165) which is open to public inspection." This is an illusion to the case which I briefly reported as the one which was the incentive among others, to the experiment for testing the question as to whether the stricture in a given case was organic or spasmodic. (Page 15, previous paper.)

Dr. Sands then cites the case as follows: "Bernard O. C., æt. thirty-five. Was admitted July 31, 1878, patient had gonorrhœa nine years ago, the discharge becoming gleet^y and lasting for six years. In the 5th year of the disease he had a perineal abscess, which healed after remaining open for ten weeks. Another abscess formed at the same site about four weeks before admission, having a fistula which had not yet closed. When admitted, he passed stream of urine about size of knitting-needle. Examination of urethra detected obstruction about five inches behind meatus, admitting only filiform bougie. At the same point, steel sound No. 25 F entered what appeared to be a false passage. High fever, with thrombosis of left femoral vein followed this examination, and no further mechanical treatment was undertaken until Sept. 26, when the deep stricture was found impassable to filiform bougies. The perin-

* A Clinical Lecture on Inflammatory and on Spasmodic Stricture, by Dr. Henry B. Sands, reprinted from HOSPITAL GAZETTE of Feb. 13, 1879.

† Italics my own.

real fistula admitted a probe, which passed about an inch upward and backward toward the bladder. Sept. 28th. Operation. Patient ætherized. Flexible bougie No. 5 F entered the bladder with difficulty, encountering resistance in the perineum; meatus which admitted No. 25 F incised, and with No. 22 F strictures diagnosed at $2\frac{1}{2}$ and $4\frac{1}{2}$ inches from meatus. These were cut with the dilating urethrotome to No. 37, *after which sound No. 35 passed without difficulty into the bladder.*"

This fairly reports a case which occurred in the service of Dr. Allen, one of Prof. Sands' colleagues, in the New York Hospital, and which was subsequently reported to the Medical and Surgical Society as, in Dr. Allen's opinion, one of deep spasmodic stricture, which had been *previously mistaken for and treated as a deep organic stricture*. He also claimed, at the same time, that the prompt and complete cure which resulted, was in consequence of the division, with the dilating urethrotome, of several organic strictures of large calibre, situated in the penile portion of the canal.

This case is cited, as Dr. Sands says, "*To show that I am (he is) not fastidious and to illustrate my (his) meaning.*" This is an apparent attempt to justify a previous statement that he has "not been able to accept the reported cases as being free from errors of observation." He then calls attention to the manifest discrepancy existing between this case and the one I referred to as having occurred in the New York Hospital, where "the perineal section had been decided upon," "notices to that effect issued"—"patient placed under the influence of an anæsthetic," etc., and which, after removal of anterior strictures by dilating urethrotome, was shown to be free from deep organic stricture by the passage of a large sound, "which slipped by its own weight into the bladder."

"The discrepancy of my own report," says Dr. Sands, "and the one I have given must at once strike every reader." He then goes on to explain.

The alleged discrepancy does, indeed, appear formidable, and would certainly be so, if it were not for the fact, that the case I cited, *was not the one he quotes*, but was one which occurred in the service of another of Dr. Sands' colleagues in the New York Hospital; (Dr.

(George A. Peters,) some time previous to the occurrence of Dr. Allen's case, and which Dr. Peters reported to me, in person, at my office, on the morning following the day of the operation. This operation was also, among others, witnessed by Professor Thomas M. Markoe, another of Dr. Sands' colleagues in the New York Hospital and Professor of Surgery in the College of Physicians and Surgeons. Prof. Markoe subsequently verified Dr. Peters' statement, to me, in regard to the case, in every essential particular. Since the appearance of Dr. Sands' paper, both Dr. Peters and Dr. Markoe have unequivocally stated to me their continued conviction that the case in question was one of chronic spasmodic stricture, and that, in their opinion, it was overcome by the division of the anterior strictures, as I have previously stated.

If Dr. Sands has not succeeded in showing that my statement of this case is incorrect, he has at least demonstrated that he is not too "fastidious."

Dr. Sands attempts to explain Dr. Allen's case, by attributing the previous failures to pass an instrument into the bladder, to its arrest in a false passage, and claims that this accident caused the error of diagnosis. That there was really no stricture of any sort, and that the previous treatment for close, deep organic stricture, was wholly a mistake.

This view of the case will be better appreciated when it is known that Dr. Allin succeeded to the service of Dr. Robert F. Weir, (still another colleague of Dr. Sands in the New York Hospital,) and that the case referred to had been under Dr. Weir's observation and care for some time, was considered by him the subject of deep, close organic stricture, and treated as such, and was so considered when the service was entered upon by Dr. Allin.

Now, Dr. Weir is well-known as an able, careful, and judicious surgeon, with an exceptionally large experience in the matter of urethral strictures, and perfectly familiar with all the expedients which guard against errors of diagnosis. We may, then, reasonably hesitate in accepting Dr. Sands' theory of the case.

M. Verneuil and M. Folet, in Dr. Sands' opinion, are deceived by "the natural obstruction in front of the triangular ligament." Dr. Weir is deceived by a false passage. Drs. Lincoln and Garnett, in the case reported in my previous paper on "Urethrisms," probably either ran against the "natural obstacle situated in front of the triangular ligament," or entered a false passage, or both. Then, again, my own numerous published cases, demonstrating that the difficulty is dependent upon a chronic spasmodic stricture, Dr. Sands says "do not impress me (him) with their validity." In point of fact, everybody is deceived but Dr. Sands. One thing, however, appears to be admitted, viz.: that the removal of the anterior strictures, followed by the introduction of a large-sized instrument, serves to clear up the diagnosis even for Dr. Sands.*

Dr. Sands has reminded us that the books of the New York Hospital are open for public inspection. To these books reference will now, for the first time, be made by me. The cases will be quoted *verbatim et literatim*: (Case Book Vol. 17, page 418.)

SERVICE OF DR. PETERS.

F. Whitehead, 33, April 20, 1878. Twelve years ago had gonorrhœa, followed by stricture. Relieved by bougies. No trouble until three years ago. Then gradual decrease in size and force of stream,—spiral. Past year urinated only drop by drop. Before operation meatus admitted 18 F. to $3\frac{1}{4}$ inches; 14 F. passed through this to $4\frac{1}{2}$ inches. Beyond that only filiform passed, with difficulty. Internal urethrotomy by Dr. Peters, April 26th, 1878. Etherized. Meatus slit with bistoury. Urethra injected with olive oil and measured. Filiform passed into bladder, followed by Maisonneuve's director. Urethrotome (blade) with cutting capacity of 12 mm. passed, dividing only anterior stricture. As No. 25 F. would not pass the $4\frac{1}{2}$ stricture, Maisonneuve again introduced. After which No. 25 F. passed down to 6 inches and stopped. Beyond this only No. 15 F. flexible passed.

Otis's urethrotome introduced, dilated to 40 mm., and anterior strictures divided, when No. 36 F. passed, without any difficulty

* "There are always those to whom it is unpleasant to be disturbed in their beliefs, or in what they have learned with toil, who, not wishing to unlearn, resent a discovery as a personal injury. There are those who cannot conceive how any one can find what they have not been able to detect." * * *. *Harvey and his Discovery*. Da Costa, p. 41.

into bladder, *showing that obstruction at 6 inches was only spasmodic and depended on strictures of large calibre, anteriorly.*

No bad symptoms followed until the fourth day, when, after introduction of a sound, had severe chill and high temperature for several days. No further trouble. When discharged could himself pass 30 F. with ease. Discharged *cured*, May 14th, 1878. This is probably one of the cases which Dr. Sands "found in the records of April and May, 1878," and which he says are "so carelessly written, however, and the facts and figures are so jumbled that I defy anybody to draw from them any definite conclusion."

I am inclined to accept Dr. Sands' defiance and to claim: 1st.—That there is a clear record of the admission of the patient April 20th, 1878. 2d.—That according to the examination of Dr. Peters the urethra was strictured to 18 mm. F. or 9 English from meatus to $2\frac{1}{2}$ inches, from thence 14 F. or 9 English from meatus to $3\frac{1}{2}$ inches from thence 14 F. or $5\frac{3}{4}$ English to $4\frac{1}{2}$ inches, and beyond this point, after careful trial, the urethra would only permit the passage of a filiform bougie. 3d.—This case was operated on (according to the hospital record) April 26th, and the urethra restored by the use of "Otis' dilating urethrotome," so that 'No. 36 F. (or No. 24 English) passed without any difficulty into the bladder." 4th.—According to the same record, the spasmodic character of the deeper and apparently the most important stricture was recognized, as shown by the statement that "*the obstruction at 6 inches was only spasmodic and depended on stricture of large calibre anteriorly.*" 5th.—That this patient who had stricture to the extent that "for the past year he urinated only drop by drop," was "discharged *cured*, May 14th, 1878, exactly eighteen days after the operation."

I am quite willing that Dr. Sands should apply his motto "*Ex uno disce omnes*," and rest upon the judgment of the medical profession for the decision as to its value.

In answer to my challenge, to be more explicit in regard to the objectionable results and complication of my operative procedures, he replies that he "has seen the slitting of the meatus carried to such an extent that the patient afterward was unable to project the stream of urine in a natural manner." This result may certainly be accepted, as Dr. Sands states that he has seen it. I would simply remark that

I should consider such an amount of "slitting" unnecessary and inadvisable. Having never slit a meatus to such an extent nor counselled any such slitting, I cannot see why I should be held accountable for such an operation any more than Dr. Sands. I insist that in all such operations the size of the meatus should be made to *correspond* with the size of the urethra behind it—nothing more, nothing less.

I would like here to remark that I do not *slit* the meatus urinaris, nor do I advise the "slitting" under any circumstances. *I divide the contracted tissues deliberately, carefully, and exactly* to the extent required to make the urethral orifice correspond to the size of the normal urethra in the given case.

Dr. Sands also says that "he knows a case in which an eminent surgeon was obliged to perform a plastic operation to restore a meatus which has been so destroyed." A very proper and simple thing, it appears to me, for the eminent surgeon to do, if such an operation became necessary. Such a necessity might however be alleged, while the meatus was no larger than the urethra behind it, as it is held by some that the meatus should be the narrowest part in order to aid in projecting the stream of urine. Discussion of this point, with Dr. Sands, before the New York County Medical Society, 1876, may be found in my book on "Stricture of the Male Urethra, its Radical Cure." Putnam's Sons, New York, 1878, p. 176, et seq. Granted, however, there was a necessity for such an operation, I should fully coincide with Dr. Sands as to the propriety of doing it. He also states that he has "seen in consultation, persons who have suffered from troublesome hemorrhage, varying in duration from several days to a month, in consequence of having been cut with the (my) dilating urethrotome, an excellent instrument of its kind, but the use of which has been carried to a dangerous excess." It appears to me that it is quite proper, and right that Dr. Sands, excellent surgeon that he is, *should* be called in consultation in cases of hemorrhage where my dilating urethrotome had been used to excess. None of these cases were mine, however, and I do not approve of the instrument being used by tyros in surgery, nor to excess by

any one. I will only say that, in my book on "Stricture 1878, p. 279, I published results of 1331 operations performed in accordance with the views I have advocated, *without a death or permanent disability of any sort.*

"Finally," Dr. Sands says, "I have heard of a number of cases in which death has resulted from the employment of the dilating urethrotome." "*It is hard,*" he further remarks, "*to obtain access to these fatal cases, which are not usually reported, and which are generally considered as a kind of private property.*"* Dr. Sands then cites three alledged fatal cases following the operation with the dilating urethrotome which he states have lately happened, two of which were said to have occurred in the previous week in one hospital. This statement is made in such a way as to convey the impression that death occurred, in each case, solely in consequence, and as a direct effect of the use of the "excellent instrument of its kind," the dilating urethrotome.

Through the kindness of Dr. Thos. M. Markoe and Dr. George A. Peters, (the surgeons in whose service the deaths referred to by Dr. Sands occurred,) I have received full notes of these cases.

Of one of these cases Dr. Sands says that the patient died from *uræmia* sixteen days after the operation. He omitted to state that, after division of the anterior strictures, continuous dilatation of the deep organic stricture, (which was left untouched in the previous procedure,) was resorted to, and instruments of gradually increasing sizes, from 5 mm. to 9, were tied in, several hours on the 12th and 15th, and retained for a longer or a shorter time on the 16th, 17th, 18th, 19th, and 22d. Tied in also from the 23d to the 24th, when the patient gave unmistakable signs of *uræmic* intoxication, and died *uræmic* on the 25th.

At the autopsy Dr. Sands says "three deep incisions were found involving the anterior $3\frac{1}{2}$ inches of the floor of the urethra, the mucous membrane of which in this situation was not thickened, *and showed no appearance of disease to the naked eye.*"* A tight organic stricture, undivided, had been treated by dilatation." The important fact that this treatment had been carried on almost continuously, and

*Italics my own.

by the tying in of the bougies, during the interval, sixteen days from operation to death by uræmia, appears to have escaped the notice of Dr. Sands, as a possible factor in causing the uræmia. It is unquestionably true that in this case death *followed* the operation of dilating urethrotomy; but for those who are familiar with the possible consequences of treatment of close deep organic stricture by continuous dilatation, that is to say, *with the instrument tied in*, it is not necessary to invoke the influence of the operation of dilating urethrotomy, sixteen days previous to account for the suppression of urine, and consequent uremia. Suppression of urine from dilating urethrotomy, performed in the anterior five inches of the urethra, is an accident which I have never seen—never before heard of—and do not esteem of sufficient probability to be worth considering in the present case.

Of the *two cases occurring in one hospital during the previous week*. The first of these was in the service of Dr. George A. Peters at St. Luke's Hospital.

D. T. S., aged 38. History of repeated gonorrhœa and of stricture. Stream size of needle, at times voided in drops.

Feb. 19th. Examination. Meatus cut to 30 F. Stricture located with bulbous sounds, one of 20 m. at $2\frac{1}{2}$ inches; 4 elastic bougie passes into the bladder; 30 bulbous sound detected a stricture at 5 inches. Otis' urethrotome introduced beyond this, screwed it up to 40, and divided the stricture, and also the one at $2\frac{1}{2}$.

On the fourth day patient complains of severe pains over region of heart; pulse rapid and irregular.

On the fifth day "Dr. Wheelock diagnosed a diaphragmatic pleurisy." Report says pain continues in side; no mention of any urethral difficulty; chest trouble goes on, and on the 12th patient develops a facial erysipelas; chest trouble steadily progresses.

17th. Flatness on left side on percussion; heart weak and irregular; died at 8 A.M.

Autopsy—"In left side of thorax were two cavities divided by a septum, in the axillary line, filled with purulent fluid; a large portion of the left lung was solid; a small portion œdematous, the large tubes containing frothy serum; on the anterior of the middle lobe was a fibrinous exudation."

Heart covered with fibrinous exudation. Pericardium contained sixteen ounces of pretty clear serous fluid.

Liver congested.

Spleen enlarged; soft and muddy color; surface covered with a

thick fibrinous exudation, and there was an ounce or two of pus near its upper portion.

Kidneys normal.

No abscesses nor other abnormalities discovered anywhere.

This case, at the time of its termination, was reported to the Medical and Surgical Society, as one of a man in bad general condition from long continued free living. The site of wound of the urethra at the autopsy was represented as perfectly healthy. No evidence of any trouble. Dr. Peters asked the opinion of the Society as to whether this could or not be considered a case of pyæmia, or whether it was not a case of idiopathic inflammation of the pulmonary and cardiac apparatus, dependent chiefly upon the broken-down condition of the patient, and bearing but a coincidental relation to the operation on the urethra. While so grave a question has been raised in regard to the cause of the trouble in this case, it does not seem to me that it can be legitimately or reasonably claimed as a case of pyæmia, and death, caused by the operation of dilating urethrotomy.

NOW AS TO THE NEXT AND LAST CASE.

This occurred in the service of Dr. Thos. M. Markoe, at the New York Hospital, the patient Thos. A. Madigan, was admitted with an ischio-rectal abscess, having also a history of a similar trouble a few months previous. April 8th, 1879, abscess opened, discharging half an ounce of foetid pus.

18th. Abscess said to have entirely healed, patient is found to be suffering from long standing difficulty of urination with history of occasional attacks of retention of urine during previous 12 years.

Is examined and found to have strictures. Meatus 21 F—Stricture at $\frac{1}{2}$ inches. No 12 F. Also several bands same size at 3 inches. April 21st, operated on with Otis' dilating urethrotome dividing strictures until No 32 *bougie a boule* passes without obstruction through the urethra and into the bladder.

22d. Had a chill followed by nausea and vomiting, temperature 101°. Half an hour later had another chill followed by temperature 104°; dropped on the 23d, to 101°; 24th, rose again to 104°; 25th and 26th, same; severe headache, throat sore, redness and tenderness over left buttock. 27th, and 28th, continued high temperature. Pain in left chest and over precordial region with dulness and diminished respiration in lower lobe of left lung. Grew gradually worse and died seven days after the operation. Autopsy revealed, among other things, miliary abscesses of both kidneys, left lobe of prostate broken down; probe passes through it into bladder. Pus also in the fluid of the left knee joint. Thus leaving no doubt as to the correctness of the previous diagnosis, viz.; pyæmia.

This case might support Dr. Sands' objection to dilating urethrotomy, were it not for the fact that during the previous month, in the same ward of the hospital, a patient was operated on by Dr. Markoe for close stricture with the urethrotome of M. Maisonneuve. This operation was followed by an attack of well pronounced pyæmia, from which, after two months of suffering, he made a fortunate recovery.

The occurrence of pyæmia in the case of Thos. Madigan, was clearly attributable to infection, dependent upon a pyæmic atmosphere, in the ward where the previous case of pyæmia had occurred and in which ward he was lying when Madigan was operated on. In order to show that this view of the case was taken by the Hospital Staff, the ward in which these accidents occurred, was vacated, cleansed and thoroughly disinfected and at the present writing, June, 18th, has not yet been reoccupied by patients. In further confirmation of the above view of the occurrence of pyæmia and the cause of death in Madigan's case, Prof. Markoe has recently stated to me, that, subsequently to the first case, several other cases occurred in the same ward, where minor surgical procedures had been followed by unusual constitutional reaction, which he now considers to have been the result of the vitiated condition of the atmosphere. With this view of the case it appears to me unfair to attribute the death of Thos. Madigan to any especial instrument or mode of operation; as much so as if the ward had been infected with the poison of *hospital gangrene*, when Madigan was brought into it after his operation, and had subsequently died of that disease.

"Finally," says Dr. Sands, "I have heard of other cases in which death has resulted from the employment of the dilating urethrotome." The character of the cases he has cited will, I think, be accepted as a proof that he has reported nearly all that he knew. I will endeavor to complete his list of alleged cases of death "resulting from the employment of the dilating urethrotome" by stating a case, which was presented for consideration at the meeting of the medical and surgical society, on the occasion of the discussion of Dr. Peters's case.

Thus: A gentleman who was under treatment for the active stage of syphilis, in about the sixth month, was also the subject of close deep long standing stricture. He was operated on, first with the urethrotome of M. Maisonneuve, and subsequently, at the same sitting, the anterior strictures were divided by means of the dilating urethrotome. These operations were followed by pyæmia, and the gentleman died.

I would simply remark in regard to this case (which Dr. Sands undoubtedly includes in his presentment against the dilating urethrotome and my views generally) that, as the division of the deeper, and much the graver strictures, was accomplished with the instrument of M. Maisonneuve, the dilating urethrotome used subsequently, cannot be clearly held responsible for the unfortunate result. I would also take the occasion here to remark that any surgeon who operates on a close, deep stricture during the progress of active syphilis, in my opinion, as distinctly invites the accession of pyæmia, as if he operated during the progress of any acute inflammatory disease; and I would hold that a death occurring from an operation performed under such circumstances can not fairly be attributed either to the method of operation nor to the character of the instruments employed. After giving in my book on the radical cure of stricture, the results of 635 consecutive operations of my own, by the plans which I have advocated, the closing paragraph, page 323, reads as follows: "I am prepared to assert that such results as I have recorded are not exceptional and may be attained by any surgeon who will provide himself with the necessary instruments for the performance of dilating urethrotomy, and use them in accordance with the plans and principles previously enforced, *and with the exercise of such judgment and skill as are considered essential to success in any other operation of like importance.*" If the procedures advocated by me are to be held responsible for the lack of judgment, and skill, and accidents of infection to which all surgical operations of equal importance are equally liable, I shall be forced to decline any personal responsibility attaching, except in such cases as are conducted under my own observation and in such a way as to meet my entire approval.

One word more in reply to Dr. Sands. In charging a large

mortality against the operation of dilating urethrotomy he makes use of a form of expression which insinuates that concealment, in other words *deception*, has been practiced in regard to the real number of fatal cases, thus he says, "It is hard to obtain access to these fatal cases which are not usually reported and which are generally considered as a kind of private property." This appears to me to be one of the side issues and personal allusions to which I referred in opening this article. It seems hardly credible that Dr. Sands fully realized the gravity of this charge when he made it. To this, however, I am glad to reply by quoting from my work on the Stricture of the Male Urethra, the note there inserted to repel a similar insinuation. After the report of 635 operations of my own, (including 18 operations by the perineal section,) with but two deaths, and these where perineal section was complicated with Bright's disease of the kidneys, (both of which are circumstantially reported,) this note follows. "Besides the
 "above reported cases, *only two other deaths have occurred in any way*
 "*associated with my practice, from cases in any degree attributable to*
 "*operations on the genito-urinary organs.*

"One, aged 78, Paterson, N. J. Here long continued and painful disease of the bladder was relieved by dilating urethrotomy. Recontraction occurred. More extensive division of stricture, resulted in relief
 "a second time.

"A week after this operation, a catheter was left in the bladder for 48 hours by the family physician. A chill, with suppression of urine, followed, and, subsequently death by uremia; distinctly *not* from the cutting operation, over a week previous, *but from the urethral irritation caused by a prolonged retention of the catheter for the relief of frequent troublesome micturition.* This was found on post-mortem examination to have been due to the presence of a small phosphatic calculus which had escaped detection during life.

"SECOND CASE.—A man of 40, suffering from close, chronic, deep stricture, came under my observation during a recent visit to Syracuse. Repeated efforts by several surgeons, during a long period, had failed to pass any instrument into the bladder. The case had become urgent on account of retention and severe suffering. Etherization was effected with great difficulty. Spasmodic tremors of the limbs continued after profound anæsthesia, so that there was much embarrassment in the introduction of instruments. After waiting and careful trial, at the end of an hour and a half I succeeded in introducing a Maison-neuve staff well into the bladder. This was followed by a medium-sized blade, subsequent to the withdrawal of which, a gum elastic catheter was introduced and the urine drawn off. The case was left in charge of the two surgeons previously in attendance. About a month later I learned that the patient had died in a comatose condi-

tion on the third day after the operation, "*after having taken largely of morphine and chloral to control nervousness and pain.*" One of the attending surgeons stated to me subsequently, that *there was no sup-
pression of urine.* No autopsy was made."

"I have been thus circumstantial in presenting the record of deaths in any way implicated with operative procedures at my hands, because it has been stated by at least one prominent surgeon in this country that *all* the deaths occurring from urethrotomy, in my practice, had not been reported, and I have also had an inquiry to the same effect made of me by several amiable friends. It is due to the operation of dilating urethrotomy, to humanity, and to myself, that further misunderstanding of this matter should be prevented, and I will say in regard to it still further that the foregoing statements cover a period of the sixteen years during which I have been a public teacher of diseases of the genito-urinary organs." The book containing this note was published July 1st, 1878. From that date to the present, June 19th, 1879, I have performed fifty-six similar operations, (five of which were combined with external perineal urethrotomy,) without a death or serious accident of any sort.* If results in the future may be inferred from the known and proven results of the past, I am confident that Dr. Sands will continue to find it "hard to find access to those fatal cases," which, from the difficulty he has hitherto found in discovering them, he has perhaps naturally concluded that they were "private property." In order to disabuse his mind and the minds of any that have been led astray by his misrepresentations, I have taken this opportunity to make my own property in the matter as public as possible.

Prof. Sands, in his discussions and published writings on genito-urinary matters, has mirrored, very faithfully, the views of Sir Henry Thompson, of London, whose sturdy conservatism is, at present, interesting the surgeons of two continents. If Professor Sands has had

* This report does not include the operations performed at my Clinique at the College of Physicians and Surgeons nor in my service at Charity Hospital during this period. A similar immunity from accidents, however, also obtained in these services.

a large and successful experience in the application of those views, as might be inferred from the tone of authority which he assumes in criticising the opinions and procedures of others, *the records of it have not yet been given to the profession.*

Dr. Sands objects (and very properly, I think,) to having the results of surgical procedures, (dilating urethrotomy, for example,) retained as "private property." Will he not then follow my example, and give to the profession all his fatal cases from operations *in any way connected with his treatment of diseases of the genito-urinary organs.* If, besides this, Prof. Sands would also state how many such cases he has treated; what the condition when the treatment was commenced; what its character; how long continued; and what its final results; he would in this way, and in this way alone, it appears to me, enable the profession to judge of the true value of his views and the validity of his claim to be considered an authority on such matters.

Professor Sands has achieved an enviable reputation throughout this country both as a teacher of anatomy, and as a proficient general surgeon. Were I, or any other surgeon, to criticise the brilliant operations on naso-pharyngeal tumors, ligatures of the carotid artery, intestinal invaginations, subcutaneous divisions of the neck of the femur, etc., etc., which he has published, no one more quickly than he, would demand the practical and well authenticated experience in such cases, that such criticism would imply. Let him then come forward with the recorded results of his experience in genito-urinary procedures. Until he does so, it may be assumed as excusable, if he is denied the right to the judicial position, which he so defiantly assumes in his discussion of the subject.

This controversy was opened by Dr. Sands professedly to consider the question of inflammatory and spasmodic stricture. I claim that it is not my fault that side issues and personal matters have been introduced, and that the original subject has been twisted into a discussion of the treatment of organic strictures by dilating urethrotomy, and its results. Now however, after having, as I believe, successfully met all the arguments which have been advanced against the existence

and importance of chronic spasmodic stricture, I am ready to discuss any other questions, however remotely connected with this subject, that Dr. Sands may choose to introduce.

But before closing this paper, I should be glad to return for a moment to the consideration of the subject legitimately under discussion, viz.: *Chronic spasmodic stricture*. The nature of my claim in regard to this matter may perhaps be best appreciated by a quotation from my paper on this subject, published in the *Archives of Dermatology*, Vol. I., No. 3, 1875.

In this paper six cases were presented, in detail, in illustration of the identity of symptoms, in organic and chronic spasmodic stricture in certain instances. Thus this latter variety of strictures were shown in the cases reported to present :

- 1st. *A gradual diminution in the stream of urine.*
- 2d. *Persistent frequency of micturition.*
- 3d. *Persistent resistance to the introduction of large instruments in the hands of skilled surgeons.*
- 4th. *Distinct grasping of small instruments, and a gradual toleration of instruments of increasing size, and in this so perfectly simulating the behavior of true organic stricture that the most skilled and learned surgeons have been deceived by these conditions.*
- 5th. *The persistence during a long period of years, of all symptoms which are recognised by authorities as characteristic of organic stricture.*

In my previous paper in reply to Dr. Sands, the case of Mr. D. J., page 16, *et. seq.* was presented as an example of one of the severer grades of urethrismus or chronic spasmodic stricture, simulating true, close, organic stricture. I desire now to call attention to a degree or variety of this difficulty, which I have reason to believe has escaped the observations of surgeons generally, viz: Urethrismus or Chronic Spasmodic Stricture simulating obstruction from an hypertrophied prostate gland. I have met with quite a number of such cases, one of which may serve as the type of this class.

Mr. W., at. sixty-four, came under my observation Dec. 25, 1876, with the following letter from his family physician: "Mr. W. is suffering from enlarged prostate gland and the symptoms which usually accompany that condition of things, and his trouble has been coming on for some time past—difficulty in passing urine, pain and straining requiring use of catheter. Treatment has been: use of catheter, warm hip baths.

Suppositories of opium and belladonna, laxatives, infus. buchu, mur. tr. iron, as the symptoms from time to time indicated, with regulation of diet, etc., etc." From the patient I gleaned the following: Never had gonorrhœa. First trouble of urinary apparatus was an attack of dysuria March, 1875, without any apparent cause, except, perhaps, drinking largely of carbonic acid water; lasted nearly a day, and passed off without treatment. Second four months after, similar to first; quite well in the interval. Again free for a month, when urinations became gradually more frequent during day, and obliged him to rise four or five times during the night; walking gave him relief. Finally had a retention of urine, lasting, with much suffering, for twelve hours. Introduction of catheter resisted. Dr. Stephen Smith, (visiting physician to Bellevue and St. Vincent's Hospitals), who was called in consultation, passed a catheter and drew off the urine. From this time, catheter used three times in twenty-four hours. No urine passed voluntarily; great urgency and frequent agonizing pain before passing catheter; great straining, involving diaphragm and abdominal muscles. This condition continued up to the date mentioned, Dec. 25th, 1876.

Examination of prostate by me shows but slight, if any enlargement. Ordinary catheter passes in without force. Urine drawn is thick with pus and mucus.

Examination of penis: circumference $3\frac{3}{4}$ inches, meatus 32, size of urethra 36 mm., from this to bulbo membranous junction, as shown by urethrometer. Quiet and infus. triticum repens prescribed. January 2, careful examination made for stone; none found. Bladder irrigated with solution of borax twice a day. Examination of several specimens of urine showed nothing but catarrhal elements. No abnormal condition could be detected about the neck of bladder, and yet the patient could pass no urine voluntarily, and as soon as he made the effort, tenesmus of the vesical neck came on, which gave great distress.

Passing urine every two hours through catheter, which he has been taught to introduce. Having seen cases of somewhat similar character and unable to find any cause for the trouble, except a spasmodic one, *I introduced with great care, bearing in mind the importance of such a procedure in a man of his age, and suffering with disease of the bladder* a 32 solid steel sound, without force, through the entire urethra. I then followed it quickly with No. 34, in order to over distend the membranous urethra, which I believed to be the seat of the trouble. A few minutes after, Mr. W. was seized with his accustomed desire to urinate, rushed in to an adjoining closet and introduced his catheter as usual. Returning somewhat hurriedly to resume conversation thus suddenly broken off, in two or three minutes he again felt desire to urinate, and believing that his bladder had been emptied, simply took up the chamber, without any idea of urinating, when to his infinite astonishment and delight, he passed with perfect ease, over a gill of urine. This was the first passed vol-

untarily since first relieved of his retention by Dr. Stephen Smith. From this time Mr. W. passed his urine *without the aid of a catheter*, on an average of every two hours for the next four days, introducing the catheter only night and morning for the purposes of irrigation. Great and rapid improvement in health and entire freedom from straining and tenesmus.

Jan. 4th, To carry out the treatment by *over-distension*, more fully, I incised the meatus to 36, the pre-ascertained normal calibre of the urethra, and passed 36 solid steel sound with complete ease through the entire urethra and well into the bladder.

From that time, the recovery from cystitis was rapid, and urine was passed voluntarily and in full stream up to Oct. 18th (over nine months), when the patient called to say that he had remained quite well up to two weeks previously, not having, in the interval, to rise during the entire night to urinate; but that, since then, having taken cold by sitting on a cold stone, his urine had presented some sediment, and his urination was with increased frequency. The only treatment (aside from *infus. triticum repens*, which he had been using on his own responsibility), was by introduction of 33 solid sound, and to do nothing else until result has been ascertained.

Oct. 19th.—Mr. W. called to say that the irritation at neck of bladder, and referred to end of penis, disappeared at once, on introduction of the sound the day previous. Intervals of urination increased to between three and four hours, rising only once during the night. Recovery from the vesical catarrh, which was but slight, was complete within the week, and Mr. W., who is still under my observation in a general way, has been entirely well of his urinary trouble from that date to the present, over two years and a half.

During a conference with Dr. Stephen Smith, subsequent to Mr. W.'s recovery, he remarked that at his first visit to the case (which had been represented as one of enlarged prostate) he was struck by the ease with which a catheter of ordinary curve entered the bladder, and, passing his finger into the rectum, he was equally surprised to find the prostate but slightly enlarged. Concluding, however, that only the enlargement of the third lobe could produce the retention, in the absence of all stricture, he had accepted the case as one of centric prostatic enlargement. A previous case in his own experience, where a patient had been apparently cured of frequent and difficult micturition by the introduction of a large sized sound, enabled him to accept my explanation of the case of Mr. W. without hesitation.

One of the significant features, in cases such as I have thus cited,

is the absence of any marked prostatic enlargement. In several, strictures of large calibre have been present. The case of Mr. D., reported in my last paper, is one of these.

Is it not possible that many cases of urinary trouble, now attributed to centric prostatic enlargement, may be due to *Urethrismus*. The absence of marked prostatic enlargement or other vesical obstructions, or close deep urethral stricture, in any case of retention, in my opinion, will warrant the introduction of a full sized sound,* as a means of clearing up the diagnosis. One which may possibly result in prompt and permanent cure.

No. 108 West 34th street, New York, June 19th, 1879. .

* By the term full sized sound, is meant, one up to the full calibre of the urethra, as indicated by the rule of proportionate relation, or by actual measurement with the urethrometer.



